Cost Control in Health Care – An Opportunity for Innovation

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Thank you for the invitation to speak with you today. I plan to tackle a topic that follows me around like my own shadow: the cost of health care.

I pick up the paper and read about how federal budget negotiators will likely cut more than $100 billion from Medicare and Medicaid over the next decade.

I pick up my laptop and click over to a recent article by Peter Orzag in Foreign Affairs, in which he writes: "It is no exaggeration to say that the United States' standing in the world depends on its success in constraining this health-care cost explosion; unless it does, the country will eventually face a severe fiscal crisis or a crippling inability to invest in other areas."

I pick up my calendar and see meeting after meeting with hospitals, doctors, insurers, managed care organizations, nursing homes, and many others … all worried about the future of health spending in our state.

I pick up the phone and hear from our team at Medicaid about the pressures facing our $7 billion program.

Sometimes, I even pick myself out of bed and realize I have just had an anxiety dream about losing my own wallet … and then finding it with my health insurance card eerily missing.

And then I realize – that's no anxiety dream for many Americans today. In my state of Maryland alone, more than 700,000 people still cannot afford health insurance.

Just when I feel surrounded by the pressure of health care costs at every possible turn … I stop for a moment and remind myself: This is why you took the job.

With mounting pressure from small business, large companies, and government, cost control in U.S. health care is inevitable.

The question is not where we are headed.

The question is how we are going to get there: Will costs be controlled by actions that harm patients … or will costs be controlled by actions that improve health?

I am here to make the case that the cost control imperative is not a crisis. It is an opportunity born of crisis … an opportunity to pursue innovation and advance public health.

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The writer H.L. Mencken, known as the "Sage of Baltimore," once said: “There is always an easy solution to every human problem—neat, plausible, and wrong.”

Many of the so-called “solutions” to rising health care costs fit this description.

Recently, I had the opportunity to participate on a panel of state officials at a national conference of small insurers. During the question-and-answer session, someone asked how a small insurance company could control pharmaceutical costs. An official from a Midwestern state, who had recently worked in the insurance industry, responded there is only one sure-fire way to control drug costs: Just keep increasing the cost-sharing until the expenditures come down to where you want them.

Some states are finding some easy solutions to Medicaid costs: Stop paying for innovative and life-saving treatments. Or cut tens or hundreds of thousands of working parents from the program altogether.

At the federal level, proposals for easy solutions share the common theme of sliding the bill for health care to states or the private sector or patients themselves. For example, federal budget negotiators have introduced the idea of a Medicaid “blended rate” that provides a single matching rate to each state … while somehow reducing federal expenditures by $50 billion or more. There’s also the idea of “block granting” Medicaid – ending the federal partnership that has sustained the program for more than 40 years.

These easy solutions are neat, plausible, and wrong. They may reduce a costs in the short run, but they largely do so by shifting the financial burden elsewhere.

And they all undermine health.

Arbitrary and prohibitive cost-sharing for pharmaceuticals and other medical technologies may force people to limit the medicines they need to function or live. Throwing parents out of health insurance may lead to more severe illnesses that prevent them from working. Shifting massive responsibilities to states will lead to draconian cuts across state government that damage critical institutions.

Over time, the easy solutions are unlikely to succeed in controlling costs. Undermine health now, pay the price tomorrow – in terms of a less productive workforce, greater uncompensated care, and stalled innovation, not to mention human desperation.

I took this job because there is another path to cost control – one that sees innovation as the route to progress.

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To explain my perspective, I would like to share two observations from my time as Commissioner of Health in Baltimore.

Put yourself, for a moment, in my shoes. You wake up every morning responsible the health of a city of 650,000 people. Baltimore is a historic city and a beautiful city but it is also a city that faces a number of serious public health challenges. You wake up to high rates of drug addiction,

teen pregnancy, infant mortality, dental decay, and asthma -- problems reflecting longstanding health disparities that are unacceptable and unjust.

Your budget is small, your authority over the health care system is negligible ... and your job is to deliver results.

Observation 1: Progress in health through innovation is possible.

The implementation of a citywide vaccine registry (which happened before my time in the city) helped make Baltimore's childhood vaccination rate one of the highest in the country. As a result, the city has a low rate of vaccine-preventable disease.

We obtained some modest grants to train doctors to prescribe buprenorphine for heroin addiction, significantly expanded access to effective treatment, and saw major declines in opiate overdoses.

We raised funds for a pilot to support pediatricians applying fluoride varnish in primary care and used data from the pilot to convince the state Medicaid program to make this intervention, which prevents tooth decay, available statewide.

Our pediatricians give out books to support reading, and test scores of young children have increased.

Our college students volunteer by the hundreds to help families access needed resources.

Our courts now show DVDs telling the stories of mothers who lost their babies because of unsafe sleep practices (a program developed after I left my post)… and there has been a decline in such deaths since.

With the right frame of mind, you can look around Baltimore and many other communities across the country and see opportunity after opportunity for progress in health.

Observation 2: Inefficiencies and misaligned incentives in the medical care system can hold back innovation and progress.

When doctors and hospitals are paid for the volume of services they provide, programs that succeed in reducing illness and hospitalizations will likely reduce revenue to health care institutions. This simple fact has long undermined collaboration between the medical system and public health.

As Commissioner of Health, I regularly read published studies describing projects conducted in Baltimore that improved health and saved lives. These projects engaged community institutions such as churches and barber shops, employed community health workers, and targeted chronically ill patients. Many had closed down after the research funding had dried up.

I was able to find some support for a few of these efforts, but we were only able to scratch the surface of what was possible.

At one point, the Fire Department came to me with the concern that some people in the city were overusing Emergency Medical Services. We set up a team through a nonprofit agency to visit those most frequent callers, find out what was going on, and help connect the patients to appropriate care. There was a man who called 911 every time he gave his wife insulin. There

was a nonagenarian who called 911 whenever she was lonely. In a paper published about the project, the team reported a 32% reduction in transports and a 79% reduction in non-transport responses. The program was cost saving in Emergency Medical Services alone.

Emergency Department doctors loved the program. But we could not get support from hospitals, because under the rules of reimbursement, our efforts were costing them money. Hospitals were paid for every Emergency Department visit and admission. Once I understood the situation, I tried to explain it to City Hall officials ... and failed. They kept pointing out that the system did not make any sense.

Misaligned incentives and inefficiencies are responsible, in part, for high rates of readmission around the country … for a major disconnect between the health care system and public health efforts that can prevent illness … and, in large part, for the very high cost of our health care system.

Cost control provides the pressure to end these failures of our health care system.

As payers reimburse for the value of health care services and not simply for volume … then the medical care system will start looking for programs and partners to keep people healthy.

As the medical system finds these partners, we will see the emergence of new sustainable funding streams for prevention and community care.

And then, with the table set, if our doctors and hospitals can identify and implement successful new programs and partnerships, we will see lower costs and improved health simultaneously.

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In Maryland, our Governor Martin O'Malley and Lt. Gov Anthony Brown see health care as an important investment in the productivity of our workforce and our strength as a people.

They are setting the expectation that innovation is the answer to health care costs -- that we can seize this moment to create new solutions that better align the health care system for health.

We are fortunate to have a head start with **innovation in health information technology**. After several years of strategic decisions and investments, Maryland now has one of the nation's leading health information exchanges, which is on track to pull in data from all of our hospitals and laboratories. It already is possible for doctors at participating hospitals to access records from other settings instantaneously.

Working with physicians organizations and with support from the Office of the National Coordinator, our state also created incentives for more than 1000 primary care doctors in our state to implement electronic health records.

Many of our health care systems are building on this infrastructure to create programs that better coordinate care and avoid preventable Emergency Department visits and readmissions.

Maryland also has a unique platform for **innovation in payment**. We are using our unique all-payer hospital payment system to create powerful incentives for better health. For example, about 10% of the state's hospital budget is under a global payment structure, in which hospital CEOs know their budget a year in advance -- regardless of the number of admissions. These

hospitals are hiring outpatient endocrinologists to manage diabetic patients, partnering with community teams to reduce readmissions, and considering a wide variety of other strategies to keep their communities healthy.

Many of the hospitals not operating under a global payment structure are signing up for initiatives on readmissions – which provide financial benefits when patients do well and do not need to come back in to the hospital. More than half of Maryland's hospital revenue is expected to be subject to these new incentives in the coming fiscal year.

These new payment structures are having an impact throughout the continuum of care. I recently visited a nursing home and they told me about a program they have to review the causes of every hospital readmission in their facility on a regular basis, in order to learn lessons to prevent such readmissions in the future.

It's a program they just started a couple of months ago.

These new payment initiatives complement existing pay for performance programs in our hospital system.

Our state's largest insurer, CareFirst, has signed up more than 3000 primary care clinicians in a medical home model that allows primary care clinicians to share savings when patients are healthier, and a statewide pilot is coordinating all payers in a medical home program for more than 200,000 patients.

We are also pursuing **innovation in public health**. Tomorrow, we will launch Maryland's State Health Improvement Process, in which our local health departments will team up with hospitals and other key partners across the state to develop local priorities and implement local actions to improve health.

These plans will tackle cardiovascular disease, cancer, and obesity and address longstanding disparities. They will help doctors care for the chronically ill and help hospitals reduce readmissions. In fact, Maryland's hospitals are providing key support to the initial phase of local health planning around the state.

We are also seeking new ways of encouraging individuals to take greater control of their own health, including by supporting dozens of businesses with innovative workplace wellness programs through our Healthiest Maryland initiative.

And we are rethinking our approach to behavioral health services out of the recognition that individuals with poorly treated substance abuse and mental health conditions can experience considerable suffering ... and accrue very high health care bills.

Maryland is the home of many companies pursuing **innovation in medical products**. Our state is supporting biotechnology and medical device development with the potential to reshape therapies for a number of devastating diseases and and actualize personalized medicine by making treatment more targeted and efficient. This support takes many forms, including indirect help for business incubators and bio arks and direct capital investment. We are also one of the only states to invest money from the global tobacco settlement in medical research on cancer –

research that is identifying new molecular targets and new diagnostic strategies that could fundamentally alter clinical practice.

As this audience knows well, progress in medical product innovation requires a public-health oriented FDA – an FDA that recognizes the potential benefits of key technologies and has the scientific expertise and resources to support product development and make timely and well-informed decisions.

But FDA approval is not enough. Many times at the agency I heard complaints from companies that even though FDA approved a medical product, many payers would not reimburse for it. To address this concern, we developed a pilot program for devices that allowed companies to seek FDA and Medicare review at the same time.

Now that I am responsible for a large public payer in our state's Medicaid program, I understand that we must seek value for our health care dollars. But I also see the need for flexible payment structures that can recognize when an investment in an expensive drug or device significantly improves function and reduces costly admissions and procedures. Smart innovation in payment and successful innovation in medical technology support each other.

As we navigate down the river of innovation in health care, federal budget negotiators could send us over the waterfall. Drastic cuts to states and health institutions will upend significant progress in reshaping our system for the better. We recognize federal health care costs must be controlled, but again, the key question is how. Governor O'Malley has recently offered **an innovative alternative** to simplistic solutions to the federal budget problems. This alternative involves rethinking the relationship between Medicare and Medicaid for "dual eligibles" -- individuals who participate in both programs. Today, Medicare pays for hospital and physician care, and Medicaid pays for support services and nursing home care.

The result is that Medicaid has an incentive for these patients to be in the hospital, where Medicare pays. Medicare has an incentive for these patients to be in nursing homes, where they are least likely to be admitted to hospitals. As a result, many patients wind up bouncing back and forth and not getting support to live their lives where they want to be -- in their homes and communities.

We can do much better these individuals. A system that permits shared savings between Medicare and Medicaid will allow more people to live at home, improve outcomes, and reduce costs.

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In Maryland, we are rolling up our sleeves to promote innovation as a solution to health care costs. We will be sharing our progress through a state-level workgroup on health delivery reform that will begin to meet this fall, and you can keep informed through following me on Twitter at @DrJoshS.

As we move forward, I must note that we are finding a willing and flexible partner in the federal government. The American Reinvestment and Recovery Act has provided key resources for our investments in Health Information Technology. The Affordable Care Act has supported a range

of public health efforts in our state. The law provides a wide range of tools to promote the triple aim: a better experience for the patient, better outcomes, and lower cost.

Fundamentally, by bringing millions of Americans into the health care system, the Affordable Care Act allows all of us to benefit from the potential of innovation.

Will we realize this potential?

My best answer to you today is: It depends.

It depends on how doctors embrace new payment arrangements that support better outcomes at lower costs.

It depends on how hospitals adapt and shift from fee-for-service reimbursement to creative alternatives that reward them for fewer re-admissions, infections, and errors.

It depends on whether insurers and managed care organizations develop innovative and successful programs that deliver better outcomes at lower cost, and are able to succeed in the market based on this success.

It depends on how communities mobilize to improve health, one block at a time.

It depends on what new progress on disease and treatment researchers can imagine, even in areas where others have given up hope.

It depends on whether companies and investors can see new opportunity in improving the value of health care and have confidence that payment systems will recognize that value.

And it depends on political leadership that does not give in to the "easy" solutions to health care costs that could set it all back.

We are fortunate in Maryland to have such outstanding professionals, institutions, and companies working together in an environment supportive of innovation and progress.

The next few months and years will be critical for this effort in our state and across the country. I urge everyone to do their part. We all stand to benefit if we can achieve cost control ... the right way.

Thank you.